LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

LEGAL ENTITY (LE) FUNDED PROGRAM/SUBPROGRAM REALLOCATION REQUEST FORM

LE Name _____ LE # _____ FY _____ Last Amendment # _____

In accordance with guidelines set forth in the DMH Policy, *Shifting Guidelines for the Legal Entity Agreement* , the above LE is requesting to shift within subprograms as shown below. The requested shift effective date is _____.

Shift From:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc

Report Name	Report Date	Claim Amt	as of Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this allocation not being spent as intended?

Shift To:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc

Report Name	Report Date	Claim Amt	as of Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this shift needed?

DMH use only:	Print Name	Signature	Date	Recommendation
Lead DC				☐ Approve as requested
Other Affected DC(s)				☐ Approve with modification modified shift amount _____ modified effective date _____
				☐ Deny

Comments/Analysis:

Deputy Director Approval:

Print Name _____ Signature _____ Date _____